USAID South Sudan Health Learning Assessment

May 2015

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USAID SOUTH SUDAN HEALTH LEARNING ASSESSMENT

MONITORING AND EVALUATION SUPPORT PROJECT

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CONTENTS

ACRONYMS

CBO	Community-Based Organization
CDC	Center for Disease Control
CES	Central Equatoria State
CHD	County Health Department
CIP	County Implementing Partner
CMO	County Medical Officer
CMT	Community Mobilization Team
CTMC	County Transfer Monitoring Committee
DFID	Department for International Development
DHIS	District Health Information Software
EMF	Emergency Medicines Fund
EU	European Union
FBO	Faith-based Organization
FCR	Findings, Conclusions, Recommendations
GF	Global Fund for AIDS TB and Malaria
GRSS	Government of the Republic of South Sudan
HHP	Home Health Promoters
HIS	Health Information System
HIV/AIDs	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HLA	Health Learning Assessment
HMIS	Health Management Information System
HPF	Health Pooled Fund
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSDP	Health Sector Development Plan
HSSP	Health Systems Strengthening Project
IDSR	Integrated Disease Surveillance and Response
IMA	Interchurch Medical Assistance
ISDP	Integrated Service Delivery Program
JSI	John Snow Incorporated
M&E	Monitoring and Evaluation
MOFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSF	Medicins Sans Frontieres
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
OFDA	Office of U.S. Foreign Disaster Assistance
PAD	Project Approval Document
PEPFAR	US President's Emergency Plan for AIDS Relief

PEST	Political, Economic, Social, Technological
PFM	Public Financial Management
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PSI	Population Services International
PSM	Pharmaceutical supply management
QA	Quality Assurance
QSC	Quantified Supervisory Checklist
QVV	Quarterly Verification Visits
RRHP	Rapid Results for Health Project
SBM-R	Standards Based Management and Recognition
SCM	Supply Chain Management
SSEPS	South Sudan Electronic Payroll System
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SIDA	Swedish International Development and Cooperation Agency
SMOF	State Ministry of Finance
SMOH	State Ministry of Health
SSP	South Sudanese Pound
SWOT	Strengths, Weaknesses, Opportunities, Threats
TB	Tuberculosis
TO	Transition Objective
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
UNOPS	United Nations Office for Project Services
USAID	U.S. Agency for International Development
VHC	Village Health Committee
WASH	Water Sanitation and Hygiene
WB	World Bank
WES	Western Equatoria State
WHO	World Health Organization

EXECUTIVE SUMMARY

OVERVIEW

The United States Agency for International Development's (USAID) health portfolio consists of a broad suite of essential, nationwide, vertical programs and state specific support, the majority of which were designed prior to the December 2013 conflict. Across the country, USAID provides support to essential medicines supply chain and procurement, disease surveillance and response, targeted programs for tuberculosis, HIV/AIDS and polio eradication, as well as water, sanitation and hygiene promotion. USAID (through the Office of Foreign Disaster Assistance - OFDA) is a major contributor of humanitarian aid across the country, including for the health sector. State specific support is provided through two programs on health service delivery and health systems strengthening in Central Equatoria and Western Equatoria States.

The purpose of the Health Learning Assessment (HLA) is to provide a better understanding of the health needs and gaps in the health care system and make recommendations for immediate and future modifications. The HLA focuses on USAID's state specific programs - Integrated Service Delivery Program (ISDP) and Health Systems Strengthening Project (HSSP) - the national-level health programs - USAID DELIVER (hereafter DELIVER), Integrated Disease Surveillance and Response (IDSR), Systems for Improved Access to Pharmaceuticals and Services (SIAPS) - and briefly touches on HIV/ AIDS commodities and technical support. The HLA also reviews the current political, economic, social and technological situation in South Sudan and USAID's support in relation to the other main donor programs and the Ministry of Health (MOH).

The assessment took place in April 2015 and relied on an extensive document review, key informant interviews, focus group discussions and field visits. The three research questions were:

1. What are the current gaps in the health service delivery and the health systems strengthening programs in South Sudan?
2. What are the strengths and weaknesses of the current model of ISDP and HSSP linking to the broader health portfolio?
3. What new or continued areas (technical levels and geographical locations) should USAID support, considering USAID/South Sudan's new framework, priorities, and areas of interest?

SOUTH SUDAN

South Sudan is in the midst of a protracted civil war. The peace talks continue with no likelihood of an imminent peace agreement. As a consequence, oil production has been disrupted—compounded by falling global oil prices—resulting in sharply decreased government revenue. Government borrowing, unsupported by foreign exchange revenues, has led to a rapid depreciation of the South Sudanese Pound (SSP). The use of technology is progressing through several health specific pilots, although there is limited governmental progress in developing enabling policies to support technological advances, such as mobile money. The country suffers from chronically low health seeking behavior, but this is improving through increased services and community outreach. The humanitarian situation continues with 1.5 million internally displaced people, leading to additional health pressures.

Despite the difficult climate, the MOH is actively attempting to increase government health worker salaries through the introduction of an Infection Allowance to bring government salaries closer to those paid by NGOs. In order for health workers to receive the new allowance, County Health Departments (CHDs) first have to implement the Human Resources Information System (HRIS) and then engage in a payroll cleaning exercise to remove 'ghost' workers and other anomalies.

Government money is flowing to the CHDs through various transfer mechanisms and health workers are receiving salaries. New initiatives such as health facility grants are also being designed to mirror the success of decentralizing funds to service delivery units in the education sector.

SOUTH SUDAN HEALTH PROGRAMS

There are three donor health programs supporting health service delivery and systems strengthening in South Sudan. The programs were, at the request of the MOH and agreed by the donor community, split geographically and designed to have a harmonized approach.

The Health Pooled Fund (HPF)—funded by the Australian Agency for International Development, the Government of Canada, the Department for International Development (DFID), the European Union, and the Swedish International Development and Cooperation Agency—supports services in six of South Sudan's ten states: Eastern Equatoria, Northern Bahr el Ghazal, Western Bahr el Ghazal, Warrap, Unity, and Lakes states. The Rapid Results for Health Project (RRHP), funded by the World Bank, supports two states, Jonglei and Upper Nile. ISDP and HSSP, funded by USAID, support Central Equatoria and Western Equatoria states.

Since their implementation, core differences among the three donor programs have emerged, in supporting hospital health care, pharmaceutical supply management, and support to local government (public financial management, coordination and supervision).

More broadly, there are a number of specific programs which provide: nationwide coverage, specific county or specific location support. Mapping the donor contributions to the three core programs and these specific programs, highlight expected future shortfalls in pharmaceuticals support and service delivery.

USAID HEALTH PROGRAMS

After the events of December 2013, USAID developed an Operational Framework to support re-entry, which links specific transitional objectives to the health programs. USAID's health portfolio has several unique support features when compared to the other donor-funded programs. The HLA identified seven unique features: 1. prevention of postpartum hemorrhage through community-based services, 2. quality improvement standards implemented at the health facility level, 3. leadership and management training and mentoring, 4. pharmaceutical supply management (SIAPS) support, 5. Emergency Medicines Fund (EMF) procurement process supported by DELIVER, 6. Integrated Disease Surveillance and Response (IDSR) program, and 7. HIV/ AIDS commodities and technical support.

GAP ANALYSIS

The majority of primary health care services are led by ISDP through County Implementing Partners (CIPs); however, gaps exist in critical areas such as family planning and secondary health care. The majority of skilled health workers are paid for through the CIPs, rather than the government; demand is much greater than supply, with strong competition for staff between implementing partners. Minor renovations and equipment procurement is occurring through ISDP and HSSP, while responsibility for major renovations fall to the other organizations, CHDs, and Village Health Committees (VHCs).

Pharmaceutical supply and management has dramatically improved due to the EMF, DELIVER and SIAPS; however, the support for county to facility supply chain management defaults to the CIPs. The EMF ends in July 2015 with no replacement mechanism planned. MOH is planning to procure a small supply of essential medicines; however, the process has stalled, with a high risk that it may not happen at all. The future of essential medicines procurement is therefore uncertain with large-scale stockouts predicted to start as early as October 2015.

CHDs have increased their leadership and management roles since the new USAID programs have begun. The MOH reporting systems are being used across the two States. However, there are weaknesses in disease surveillance systems and parallel supervision processes across USAID supported programs. There is a gap at the national level for coordination across the core health

programs. At the state and county level, there is inconsistent planning linked to the broader health sector and the MOH Health Sector Development Plan.

ISDP AND HSSP MODEL ANALYSIS

The IDSP and HSSP models allow for focused support to service delivery, community activities, and health systems strengthening. ISDP has been able to focus and concentrate on service delivery and community activities, bringing technical expertise on maternal and child health activities. HSSP has been able to focus and concentrate support on strengthening the CHDs, which has proven successful.

The design, however, assumed transition of key functions to the MOH, which has not been possible. The split has meant two sets of overheads and additional administrative activities. It has created potential duplication of efforts at the community and facility levels. Furthermore, critical gaps have emerged, for example: responsibility for the facility level pharmaceutical supply management, no support for secondary care, and no support to increase the number of skilled health workers

CONCLUSIONS

The upcoming end-dates of ISDP, HPF and RRHP, provide the donor community a window to harmonize approaches and fill nationwide gaps using each programs' unique features. There is also room to learn from the other core health programs, as well as to decrease the identified gaps in the health system. Any realignment of USAID programs should use USAID's Operational Framework, and address the weaknesses in the HSSP and ISDP design through improved collaboration.

The South Sudan environment has changed since the programs' design, with increased conflict and an increasingly fragile economy. The uncertain future supply of essential medicines is a critical threat to service delivery. Other donors have increased their responsibilities in the current program cycles, potentially suffering from mission creep due to pressures from the MOH. As a result, all donors may find it difficult to maintain the current levels of program delivery.

RECOMMENDATIONS

Within the current funding envelope, support to basic service delivery should continue as USAID is the main vehicle delivering primary health care services in Central and Western Equatoria. USAID and ISDP should work with other donors to standardize health worker salary payments and benefits. USAID programs should increase efforts to shift oversight responsibilities to the CHD, as well as support the development of comprehensive planning at the county and state levels. Resources could be better used if duplications were removed; staff was embedded in the county and state offices for systems strengthening, and all responsibility for community activities were transferred to the CIPs. There should be an increased emphasis on disease surveillance systems.

Outside of the funding envelope, the Emergency Medicines Fund (EMF) must continue, as the MOH supply remains uncertain, there is no other viable choice available. To compliment this, the long-term supply management at the local level must improve to better utilize and store the essential medicines already procured, an ongoing issue for several program cycles. USAID should roll-out its unique service delivery expertise nationwide, increase support to reducing maternal mortality, and implement the HRIS as soon as possible.

FUTURE DESIGN

The limited resources, increased responsibilities of donors, and unique features of each donor, means that a different approach is needed to capitalize on development partnerships. USAID should move towards a pooled fund mechanism for service delivery and health systems strengthening. Such pooling will reduce transaction costs and allow other donors to take responsibility for non-USAID health activities such as secondary and tertiary care, allowing USAID to scale up implementation within its areas of technical expertise. The timelines of core health programs provide an ideal opportunity to start discussing the new model design in June 2015, with the aim of aligning programs

by June 2016. Therefore, USAID should immediately initiate the Project Approval Document (PAD) process.

The unique features of USAID's health portfolio should expand to provide nationwide technical support. Long-term solutions for procurement of essential medicines and county storage infrastructure are critical factors for future programming, which also requires a collaborative approach across donors.

The immediate next steps are to start discussions and analysis on the feasibility of the pooled fund, and initiate the PAD process. USAID should consider holding a joint review with the core health programs and main donors to collate countrywide lessons learned.

INTRODUCTION

PURPOSE

The HLA is intended to provide the USAID/South Sudan health team with a better understanding of the current health needs and gaps in the healthcare system in terms of its delivery strategies, as well as an understanding of where USAID should engage in the future. It will enable USAID/South Sudan to reach decisions relating to any modifications necessary to improve or refocus its health portfolio in light of the current political and economic environment. Furthermore, the assessment will explain the strengths and weaknesses of the present model and approaches to health service delivery and systems.

SCOPE OF ASSESSMENT

The HLA covers key health portfolio programs, including national-level vertical programs and state specific support in Central Equatoria State (CES) and Western Equatoria State (WES), taking into consideration the USAID Operational Framework for South Sudan (particularly Transition Objective 1.2: Deliver critical services and 3.1: Maintain critical functions). The HLA also draws findings from across the health system funded by other partners.

USAID national-level health programs include the USAID DELIVER Project, Integrated Disease Surveillance and Response (IDSR), Systems for Improved Access to Pharmaceutical Services (SIAPS), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and Challenge TB. Further details are provided in Table 4. This assessment, however, focuses on DELIVER, IDSR, and SIAPS.

At the state level, the HLA covers the ongoing programs of Integrated Service Delivery Program (ISDP) and Health Systems Strengthening Project (HSSP). A detailed review of the activities of ISDP is not part of the HLA, as the ISDP Mid-Term Evaluation has been commissioned for this purpose.

RESEARCH QUESTIONS

The HLA addresses the three research questions in Table 1. The table indicates where each question is answered.

TABLE 1: RESEARCH QUESTIONS AND WHERE THEY ARE ADDRESSED IN THIS REPORT

Question	Description	Section
1. What are the current gaps in the health service delivery system and the health systems strengthening programs in South Sudan?	– Compare USAID's design and the activities with the main service delivery and health system strengthening models in South Sudan, in particular HPF and RRHP – Develop a brief mapping of key donors – Analyze activities in CES and WES across the six health systems pillars – Document USAID's unique support areas	– 2C – 2C – 2D, 2E – 2D
2. What are the strengths and weaknesses of the current models of ISDP and HSSP linking to the broader health portfolio?	– Analyze the strengths and weaknesses of the design – Identify opportunities and threats which will factor into the recommendations	– 2E – 3A, 3B
3. What new or continued areas (technical, levels and geographical locations)	– Relate current activities with USAID Operational Framework and health strategy – Use 'if – then' statements in the recommendations to	– 2D – 4

should USAID support, considering USAID/South Sudan's new framework, priorities, and areas of interest?	account for likely scenarios – Make specific immediate and future recommendations for USAID	– 4A, 4B

METHODOLOGY

The HLA team conducted an extensive review of all relevant project-specific documents, progress reports, government policies/strategies, and other donor program documentation.[1] Nearly 50 key informant interviews were conducted across all levels of the health system, including partners, using structured interview guides.[2] Site visits were undertaken at all levels of the health system to get a snapshot of health services. Two focus group discussions were also held to hear from the health workers and community. The HLA did not conduct a detailed review of service delivery or community activities, as this is covered by the ISDP Mid-Term Evaluation.

TABLE 2: SUMMARY OF METHODS AND DATA COLLECTION TOOLS

Activity	Completed	Data collection tool
Document Review	– All relevant project documents – GRSS documents – Donor program documents	Key findings template, mapping templates
Key Informant Interviews	– 49 interviews covering MOH, MOFEP, SMOH, CHD, health workers, CIPs, Jhpiego, Abt Associates, Fund Managers, USAID, other donors and NGOs	Semi-structured interview guides
Focus Group Discussions	– Village Health Committee – Primary Health Care Centre health workers	Focus group discussion guide
Site visits	– Site visits to ISDP supported facilities in WES and CES (urban and rural in both), four CHD offices, two county/SMOH stores, and two SMOH offices	Semi-structured interview guides

DATA ANALYSIS METHODS

The qualitative data sets collected above have been analyzed using tools such as Strengths, Weaknesses, Opportunities and Threats (SWOT); Political, Economic, Social, and Technological (PEST); and, the Findings, Conclusions, Recommendations (FCR) frameworks. No major primary quantitative data collection methods were employed for this assignment. Where financial data has been used, it has been secondary analysis using existing data with sources cited.

The team collected a large evidence base (just under 50 interviews were held in which over 80 individuals took part), using a systematic approach to record and analyze information across sources. This information has been triangulated against secondary sources so as to reduce any bias and cover gaps. Two debriefs were conducted for USAID to comment on the findings, conclusions and recommendations. Furthermore, results were presented to the ISDP Mid-Term Evaluation team to corroborate findings.

[1] See Annex B : List of Documents
[2] See Annex C: List of Key Informants and Annex D: Interview Guides

The six pillars of health systems[3] have been used to identify the types of interventions supported and current gaps. These pillars are:

- Service delivery;
- Human resources for health;
- Health infrastructure development and maintenance;
- Pharmaceuticals, medical supplies and equipment;
- Supervision, monitoring and evaluation; and
- Finance, leadership and governance.

LIMITATIONS

The HLA was primarily qualitative in nature, collecting subjective information surrounding the three research questions. This approach thus includes a heavy reliance on qualitative data and memory of experiences (potentially leading to recall bias). In addition, only a limited number of sites were visited, with first choice locations not accessible due to insecurity.

RESEARCH FINDINGS

SOUTH SUDAN

Political

The ongoing peace talks taking place in Addis Ababa are entering a new phase, which brings additional parties into the talks, including other African nations, the Troika, EU, China, and the Intergovernmental Authority on Development. Issues still to be resolved include debt, representation in the transitional government, the structure of the army, the length of integration/ transitional periods, as well as national elections.

There is widespread criticism that the talks are not inclusive enough of civil society, and that they do not sufficiently address inter-communal violence. Rather, they are widely interpreted as power sharing negotiations between an elite few which undermines the prospect of lasting peace resulting from an agreement.[4]

The conflict continues in Jonglei, Upper Nile and Unity. During the HLA, renewed fighting broke out in Upper Nile State between Sudan People's Liberation Army soldiers. The risk of conflict with Sudan increased briefly when South Sudan delayed its payment of transit fees due to a shortage of dollars.

The health sector is being affected both economically and socially by the lack of an imminent peace agreement, the continued internal conflict, and tensions with Sudan.

Economic

Lower oil production, principally from Unity State, compounded by falling global oil prices have contributed to a sharp reduction in revenue for the Government of the Republic of South Sudan (GRSS). This situation is likely to persist as the prospect of production returning to pre-crisis levels seems unlikely due to declining reserves and damage to oil infrastructure as a result of fighting.[5] The government is committed to increasing non-oil revenue, which now accounts for between one

[3] As per the six pillars of the health system in the MOH Health Sector Development Plan 2012-2016, modified but based on the WHO building blocks of the health system. The WHO six health systems building blocks are: HRH; health finance; health governance; health information: medical products, vaccines, and technologies; and health services.
[4] Democracy, Human Rights and Governance Assessment Revisited: 2012-2015, USAID April 2015
[5] US Energy Information Administration analysis, available online at: http://www.eia.gov/beta/international/analysis.cfm?iso=SDN

quarter and one third of all revenues, but is struggling to maintain levels due to increasing non-compliance.[6]

GRSS expenditure is above projections, despite line ministries being set to spending ceilings. This is due to increased spending related to the conflict and peace talks.[7] To fund its expenditures, the GRSS is borrowing from the Bank of South Sudan. This is leading to a widening fiscal gap and an increase in the money supply, unsupported by foreign exchange reserves. The latter is a major factor contributing to the recent and rapid depreciation of the South Sudanese Pound (SSP), increasing inflation and eroding the purchasing power of the SSP.[8] At the time of writing, the black market exchange rate had passed USD 1: SSP 10.

Discussions with the International Monetary Fund for financing are ongoing and in early 2015 a $ 500 million loan was secured from the Qatar National Bank.[9] External borrowing will not pose the same inflationary risk, and is therefore a sign of a more pragmatic approach by the Government.

Linked to the economic situation, interviews revealed that the MOH is planning to procure a small supply of essential medicines; however, the process has been stalled due to a lack of available funds and inability to issue a letter of credit to suppliers.[10] The supply is not guaranteed and there is a high risk that it may not come to fruition.[11]

As a result of the increased inflation, there are reports of increased pressures on NGOs to pay health workers' salaries in USD, with some already having made the transition.[12] While the rationale for each individual NGO and health worker is clear, this undermines attempts to harmonize NGO salaries and reintroduces unhealthy competition into the labor market – this will be counter-productive in the long run. In addition, it undermines attempts by the MOH to raise government-employed health workers' salaries in line with NGOs through the introduction of the Infection Allowance[13].

Despite the economic climate, the Infection Allowance is still considered feasible, as the increased cost would be offset by a cost-saving payroll cleaning exercise. The MOH is actively supporting the Infection Allowance; in 2014, the MOH requested Ministry of Finance and Economic Planning (MOFEP) to transfer funds from their operating budget, partly to fund Infection Allowances.[14] The government has also shown a commitment to prioritizing state and county level salaries, verified by the HLA team at the facility, County Health Department (CHD), and State Ministry of Health (SMOH) levels; as well as with the MOFEP.

Other increased support, such as the introduction of a grant to health facilities, is still being discussed with the administrative and funding arrangements as yet not finalized.[15]

Social

With over 1.5 million people displaced since December 2013, the humanitarian response will need to continue even after a peace agreement is implemented.[16] The IDP camps are presenting a new set of health needs: increased birth rates, potential gender-based violence, and increased risk of outbreaks. This assessment does not address the health needs of IDP camp residents, nor does it cover the challenges of transitioning from humanitarian aid to development assistance in the three main conflict states.

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[6] 2014-2015 First Macro Fiscal Report, MOFEP, November 2014
[7] Ibid
[8] Note from Department for Macroeconomic Planning, MOFEP – Weekly Exchange Rate Developments, MOFEP, 14th April 2015
[9] Based on interview responses, matching news reports available online at: http://eyeradio.org/south-sudan-borrows-500m-qatar/
[10] Interview Notes from the Health Forum Advisory Team, group of elected NGOs.
[11] Interview Notes with national MOH
[12] Letter from MOLPSHRD, Clarification on Circular No 8/2012, September 2014
[13] See next section for details
[14] Letter from MOH to MOFEP, Realignment of SSP 37m from Operating to Transfers Chapter, 29th May 2014
[15] Note from Health LSS Meeting, MOFEP, 26th March 2015
[16] Source South Sudan Humanitarian Snapshot 15th May 2015

Maintaining basic services in conflict affected areas are becoming increasingly difficult - it is estimated that 184 facilities in Unity, Upper Nile and Jonglei have been destroyed, occupied, or are no longer functional.[17]

In areas that are not directly affected by the conflict, such as CES and WES, health seeking behavior is persistently low. Field observations and interviews showed signs that the mobilization of Home Health Promoters (HHPs) is helping to address this, but it is still a major concern, exacerbated by an increased prevalence in user fees in both CES and WES.

Technological

There has been limited governmental progress in developing and introducing enabling policies to support technological advances, such as the introduction of mobile money. However, there are precedents for progress without such legislation as is the case in Kenya. Mobile network operators are investing in developing mobile-money technology for South Sudan. Despite poor cell phone coverage in isolated areas, such a development would introduce greater possibilities for the health sector.

Pilots have been implemented to trial new technologies. These include a small pilot on electronic birth registration in Eastern Equatoria State. Training has also been provided to specific national-level staff on the use of the District Health Information Software 2 (DHIS2); however, implementation has not yet started.[18] HSSP have also submitted a proposal to introduce mobile technology for data entry of health facility quality assurance visits.

GOVERNMENT INITIATIVES IN HEALTH

MOH Infection Allowance

NGOs should be using a Harmonized Salary Scale, standardized across the country.[19] The MOH salary scale is far below the NGO Harmonized Salary Scale and causes disincentives to government health workers, contributing to absenteeism and poor performance. The MOH is unable to change the government salary scale as this would require Ministry of Labor and Public Services approval and be applied across the entire civil service. However, the MOH is able to introduce an allowance to effectively raise the level of salaries received by health workers to a similar level as the Harmonized Salary Scale: the Infection Allowance.

In order for health workers to receive the new allowance, CHDs first have to implement the Human Resources Information System (HRIS) and then engage in a payroll cleaning exercise to remove 'ghost' workers and other anomalies. The savings from this exercise will be used to fund the Infection Allowance. There are eleven counties across the two states, Western Bahr el Ghazal and Eastern Equatoria, which have completed the Infection Allowance procedure and health workers have started to receive their allowance.[20]

Human Resource Information System (HRIS)

The MOH has developed an updated HRIS, whose implementation has progressed from testing to capturing data across five states (excluding CES and WES), with a live update available on www.hrisrss.org. The HRIS captures basic details and photos, qualifications and work history of health worker staff. It is established to capture both government and NGO workers.

Health Facility Grant

[17] South Sudan Humanitarian Response Plan 2015, OCHA South Sudan, December 2014
[18] Interview Notes with national MOH
[19] Common Salary Scale for Primary Health Care Workers in South Sudan, MOH, 4th April 2015
[20] As of 30th June 2015. Source, HPF PFM Advisors.

The proposal to develop a health facility grant partly based on the schools' Capitation Grants, which are already being disbursed under the leadership of the Ministry of Education Science and Technology, was made in the Local Services Support Technical Working Group in 2015.[21] It is still under discussion, with no final decision as to which facilities would be eligible for the grant, how it should be used, and how it will be funded. The grants are likely to be used for PHCCs, where the facility will be accountable to the CHD and the community through the Village Health Committee (VHC). There is no additional government resources expected for 2015/16 in the health budget, therefore the scheme would have to be financed through savings in the existing resource envelope.[22]

County Budget Overview

All states are mandated to establish County Transfer Monitoring Committees (CTMCs) to oversee county budget planning, execution, and reporting. CHDs should budget for transfers to facilities to cover their own operating expenses within their funding envelope. The main sources of funding to CHDs are the County Development Grant, County Block Grant, Conditional County Salaries, and Operating Transfers, all transferred from the central government.[23] [24] At the county level, the funding must be divided up to distribute among the different sectors (health, education, etc.).

County Development Grant

This is a conditional but discretionary development grant allocated to each county, based on its population size. It is to be used for infrastructure development, with not more than 50 percent of the grant to be spent on administrative infrastructure. Spending priorities are either decided through a consultative process with payams and bomas, or by the County Executive Committee (CEC). The grant is budgeted by and transferred from the State Ministry of Finance (SMOF) to each county in two tranches per year, depending on compliance with reporting requirements.

County Block Grant

This is a discretionary grant that counties can use for any priority, in any sector, as they can with their own resources. Monthly transfers are budgeted and executed by the SMOF to each county.

Conditional County Salaries and Operating Transfers

These are sector-specific conditional transfers. Two monthly transfers are made to the CHD: one for salaries and one for operating costs. They are budgeted for by the CHD, and included in the SMOH budgets, with transfers executed by the SMOF.

SOUTH SUDAN HEALTH PROGRAMS

Core Health Programs

In 2011, the MOH requested, and the donor community agreed, to a geographic split. The intention was that all partners would implement a similar health package, using a harmonized approach to ensure similar services were provided across the country.[25] This split involved three core programs between three donors/funds:

– Health Pooled Fund- support Northern Bahr el Ghazal, Western Bahr el Ghazal, Unity, Warrap, Eastern Equatoria, Lakes states;

[21] Note from Health LSS Meeting, MOFEP, 26th March 2015
[22] Ibid
[23] State and Local Government Health Sector Planning Budgeting and Reporting Guidelines for Fiscal Year 2014/15, MOH
[24] Guidelines for County Planning and Budgeting for Fiscal Year 2013-2014, MOFEP
[25] Summary notes from the 'Financial and Technical Support to Implementation HSDP Workshop' 29-30 November 2011, MOH.

- World Bank's Rapid Results for Health Project support Jonglei, Upper Nile states;
- USAID's Integrated Service Delivery Program and Health Systems Strengthening Project support Central Equatoria and Western Equatoria states.

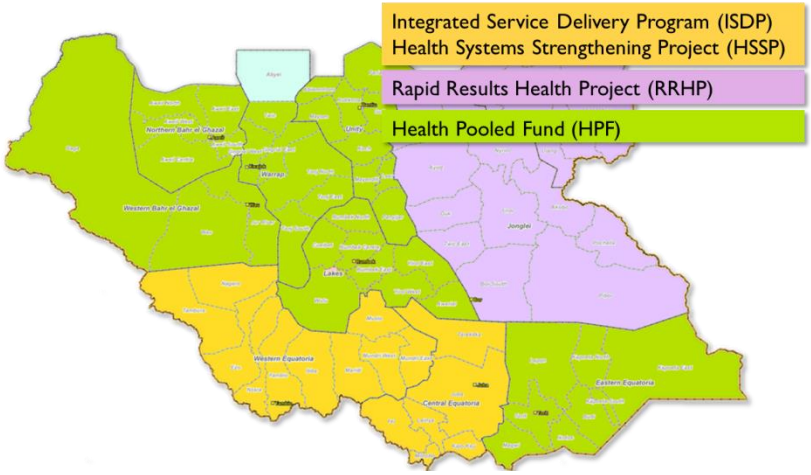


Figure 1: South Sudan by geographical split of main health programs

Health Pooled Fund

The Health Pooled Fund (HPF) is funded by five donors: Australia, Canada, the European Union, Sweden and the United Kingdom. The donors contribute £120 million through the HPF, to provide funds over 3.5 years, for service delivery (including hospital support), community based activities and health systems strengthening. The fund manager is Crown Agents, who works in consortium with agencies that provide overall technical support to CIPs. The HPF is overseen by a steering committee chaired by the MOH, and co-chaired by DFID at the national level. It is scheduled to end April 2016 (CIP contracts end December 2015). [26]

Rapid Results for Health Project

RRHP is funded by the World Bank through a mix of grants and loans to the MOH in the order of $60 million.[27] IMA (Interchurch Medical Assistance) is the fund manager overseeing the performance-based contract which began in August 2012 and will end in October 2015 (NGO contracts end earlier). Similar to the other core funds, RRHP utilizes CIPs, of which IMA is also one. RRHP uses results-based financing contracts with CHDs and facilities, and hardship incentives to health workers which currently remain in place. RRHP is responsible for two of the most conflict-affected states, which has hampered the ability for IMA and many CIPs to operate normally.[28]

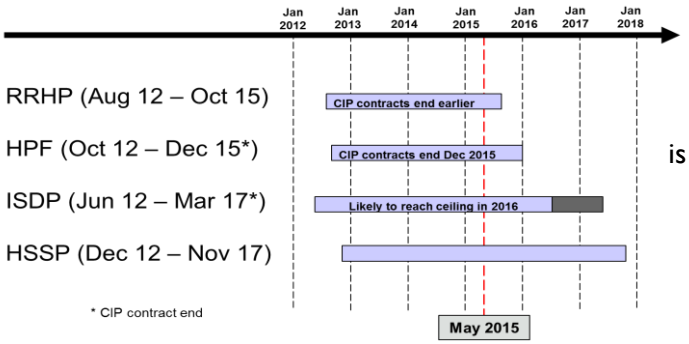


Figure 2: Timeline for core programs

Integrated Service Delivery Program

ISDP is an $85 million dollar fund led by Jhpiego with implementation sub-contracted to CIPs. ISDP supports service delivery and community based activities. The program ends March 2017; however, on current projections, their ceiling will be reached mid-2016.[29]

Health Systems Strengthening Project

HSSP is a $25 million program led by Abt Associates, to increase ownership and capacity of SMOHs and CHDs to ensure the provision of high-quality primary health care services. HSSP ends November 2017.

[26] Health Pooled Fund: South Sudan Mid-Term Review Report, January 2015
[27] $28m approved in 2012 followed by additional financing of $35m in 2014. Implementation and Status Report, public disclosure copy. 2014.
[28] Interview Notes with IMA
[29] Interview Notes with USAID

Similarities and Variations between Core Health Programs

Table 3: Snapshot of core health programs

Pillar		ISDP	HSSP	HPF	RRHP
Service Delivery	PHCU/ PHCC	x	x	x	x
	Hospitals			x	x
Human Resources for Health	Pre-service				
	In-service	x	x	x	x
Health infrastructure	Minor Renovation	x	x	x	x
	Major renovation				x
Pharmaceuticals, med supplies & equipment	Top-up medicines			x	x
	Equipment	x	x	x	x
Supervision, monitoring & evaluation	Supervision	x	x	x	x
	Monitoring tools	x	x	x	x
Finance, leadership and governance	VHCs	x	x	x	x
	County Transfers		x	x	
	PFM Support		x	x	
	Coordination	x	x	x	x
Approach	CIPs Contracts	x	x	x	x
	Conflict Sensitivity			x	x
	Other	Community	Hubs	State Fund	PBF/QVV

Specific examples of similar activities which the programs are implementing include:[30]

- Primary health care service delivery support;
- Use of government Health Management Information System (HMIS);
- A common set of service delivery indicators;
- Support to CHDs;
- Capacity building and empowerment of VHCs;
- Joint supervision (CHD and CIP) of health facilities.

All three programs are supporting service delivery at the PHCC and PHCU level. ISDP, HPF and RRHP support service delivery through the contracted CIPs. HSSP supports in-charges through their leadership program. The USAID programs are not supporting hospitals unlike HPF[31] and RRHP[32]. HPF has expanded its hospital program to include faith-based and government hospitals.

All programs provide in-service training for health workers. HSSP, RRHP and HPF also provide training and support to the CHDs. No program provides pre-service training.

Medicine procurement (supplementary to the EMF), is carried out by CIPs in the HPF and RRHP programs. In the HPF, the CIPs procure and transport the medicines, and HPF provides technical support. In the RRHP, IMA procure, store, and help distribute the medicines through their CIPs. All programs provide equipment for health facilities or the CHDs.[33]

Minor renovation of health facilities or the CHD offices is supported by all programs. RRHP has also supported major renovations caused by the conflict.

[30] Presentations from the Donor Harmonization Workshop, South Sudan Fund Managers, 2013
[31] HPF has launched Requests for Proposals for county and state hospitals in 2014
[32] South Sudan - Additional Financing for the Health Rapid Results Project, World Bank, 2014
[33] Interview Notes with HPF, IMA, HSSP and ISDP

All programs supervise service delivery through the CIPs and use the MOH Quantified Supervisory Checklist (QSC), with a focus on joint supervision (CHD and CIP) of health facilities. ISDP also uses a quality improvement tool described later in this report. Data from the health facilities is collected using the MOH health facility monthly report.

All programs support VHCs through supporting current committees and establishing new ones as well as training members. Public financial management (PFM) is not addressed in the RRHP[34] or ISDP. HPF and HSSP support CHDs with county budgets and transfers. Some HPF[35] and RHHP locations are implementing government initiatives such as HRIS and the South Sudan Electronic Payroll System, while USAID locations have not yet utilized these initiatives. HSSP is delivering a leadership and management training program described later in this document. All programs hold Quarterly Review meetings with the CHD and CIPs, to aid coordination and monitor progress. HPF embeds staff in the SMOH, and uses national and state oversight committees to coordinate with the MOH.

All service delivery programs (ISDP, HPF and RRHP) provide services through CIPs with one implementing partner per county. RRHP also contract-in a number of CHDs to manage implementation of services.[36] RRHP uses performance based contracts with health facilities, CHDs and hospitals, paying incentives based on targets.[37] HPF and RRHP have implemented specific conflict strategies in Unity, Jonglei, and Upper Nile states, including expanding service delivery through mobile health clinics to reach affected populations.

Other unique activities within respective approaches include the following:

- HSSP uses a 'hub' model[38] grouping counties together to provide follow up and training;
- HPF provides a State Fund to each SMOH through a CIP. The fund allows the SMOH and CHDs to pay for supervision visits, operating expenditures, transportation, training courses and hiring additional staff. It also includes the ability to purchase vehicles and renovations to offices;[39]and
- RRHP has independent Quarterly Verification Visits (QVV), where health service delivery data is verified by a third party.

Vertical Programs

The HLA analysis focuses on three of the following programs (IDSR, DELIVER & SIAPS) which work alongside the core three programs. Other programs are not elaborated, but will need to be factored into future USAID programming.

[34] MOH instructed RRHP that this was MOFEP's responsibility and the World Bank has separate technical assistance programs in this area.
[35] Health Pooled Fund: South Sudan Mid-Term Review Report, January 2015
[36] Ibid
[37] 'The RRHP Project Common Elements and Unique Features' IMA Presentation of RRHP at June 2013 Harmonization Workshop
[38] HSSP is introducing 6 'hub's in the 2 states (one hub per 2-3 counties) to provide implementation support at a more local level (previous model was supported from Juba). Hubs are used to bring CHDs together to exchange ideas and review progress between counties.
[39] Support to Enhance State Ministries of Health Supervisory Capacity, HPF, 2013

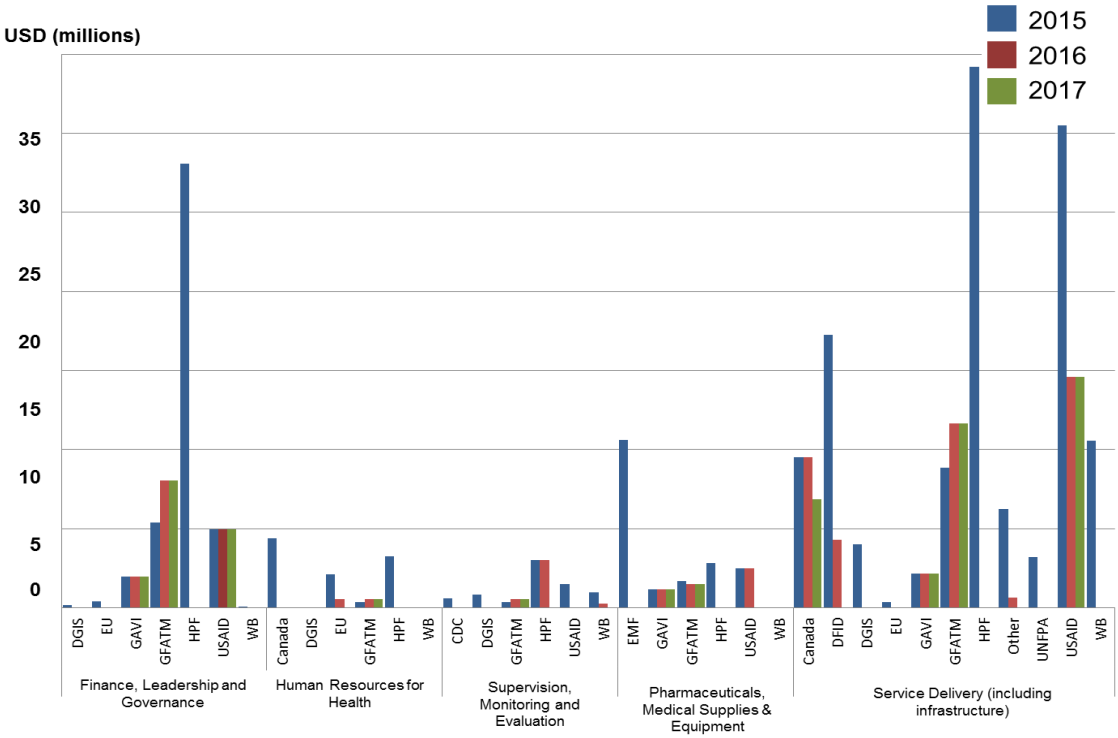
TABLE 4: SUMMARY OF KEY VERTICAL PROGRAMS [40]

Program	Donor	Lead	Summary Status	Key activities
Integrated Disease Surveillance and Response (IDSR)	USAID	WHO	Active; annual funding	Coordinate outbreak investigation and response, technical support to implementing partners
Emergency Medicines Fund/DELIVER	USAID, DFID, NORAD	JSI	Active; 1 year stop gap funds	Stop gap funding for essential medicines
Systems for Improved Access to Pharmaceuticals and Supplies (SIAPS)	USAID	MSH	Active; global program	Pharm management strengthening, support to national malaria program
Global Fund AIDS, TB, Malaria	GF	UNDP	Malaria grant now active. No new funds for TB and HIV; next round application submitted	Drugs, supplies, commodities; national policy, tech support
Integrated Community Case Management (ICCM) program	DFID	PSI	Linked with Global Fund	Community treatment M/D/P, training, SCM
Challenge TB	USAID	MSH	Next phase of 'TB CARES'	Community-based approach; TB testing QA, WES/CES support in facilities
LINKAGES/CDC/ICAP (PEPFAR)	USAID	FHI/IH	LINKAGES recently commenced	LINKAGES- female sex workers, HIV prevention & treatment through community mobilization; CDC/ICAP- ART, ANC surveillance
SPPHC	USAID	Jhpiego	Start-up phase	Scaling up Option B+ at PHCCs
Strengthening Midwifery Services	Canada	UNFPA	3 year funding comes to end in 2015 (extension expected)	Pre-service training in Wau, Maridi, KajoKeji, Juba
Strengthening Emergency Obstetrics Care in Hospitals	Canada	WHO	Ends in 2016. Likely handover to HPF partners in relevant areas	UNVs placed in Bor, Yambio,Aweil, Torit, Kwajok, Wau
Strengthening Immunization Services and Systems in South Sudan	GAVI	UNICEF	National program	Standard immunization programming including meningitis campaigns

[40]Vertical programs included are those which exceed a multi-year value of over $5m

Donor Contributions to Health

The broader activities in the sector must be considered in the analysis of the USAID health portfolio in order to see where other partners are making active contributions. The analysis below is based on the data collated for the 2014 Donor Mapping through the Health Sector Working Group.[41] The data has been restructured to analyze the proposed donor contributions across the six health system pillars from 2015 to 2017.[42] It highlights additional donor funding outside of the three core programs. Where there are no bars next to the donor, this means that they have stated there is no confirmed contribution.



Source: Based on 2014 Donor mapping (with further analysis)

Figure 3: Donor contributions by health pillar, per annum (2015-2017)

Not all funding streams have contributed data, e.g. UNICEF or WHO. The data for ISDP and HSSP can only be disaggregated under two pillars: Service Delivery and Finance, Leadership and Governance; however, the programs provide resources to all pillars. It also does not show the MOH planned contribution towards each pillar. Even with these limitations, there are key points to note:

- Overall funding for 2016 and 2017 has gaps, due to the HPF and RRHP ending this year;
- HPF contributes the most towards Finance, Leadership and Governance which includes support to PFM. USAID's contribution is from the HSSP project.
- Canada and the EU provide the most support to pre-service training institutes shown in Human Resources for Health.
- Supervision, Monitoring and Evaluation is least well-funded, with USAID's contribution shown through IDSR. However, it is noted that both HSSP and ISDP provide support in this area, although the data cannot be shown in this pillar.
- There is a decrease in funding for pharmaceuticals after the Emergency Medicines Fund (EMF) ends in 2015. USAID allocations for 2015 and 2016 shown, are to SIAPS.

[41] Donors/MOH Investment Map 2012-2017. Compiled by Embassy of Canada on behalf of the Donor Partners Group and presented on April 9, 2015. Corresponding Excel-based data was used for further analysis. The HLA did not collect this data but used data available for the analysis.

[42] Original data received includes infrastructure within service delivery, therefore five pillars are shown.

- Service delivery is most well-funded. The data includes donor contributions to both primary, secondary health care and infrastructure.

USAID PROGRAMS

Operational Framework

After the events of December 2013, USAID developed a strategy to support re-entry, focusing on an overall goal of 'building a foundation for a more stable and socially cohesive South Sudan' with three core transition objectives (TOs). As this strategy was developed after the health programs were already in place, the health team fit their programs into the strategy's TOs. While programs and TOs are linked, there is not an explicit link between program activities and health indicators with the sub-TOs. USAID's health team is currently adapting health indicators to match the new framework.

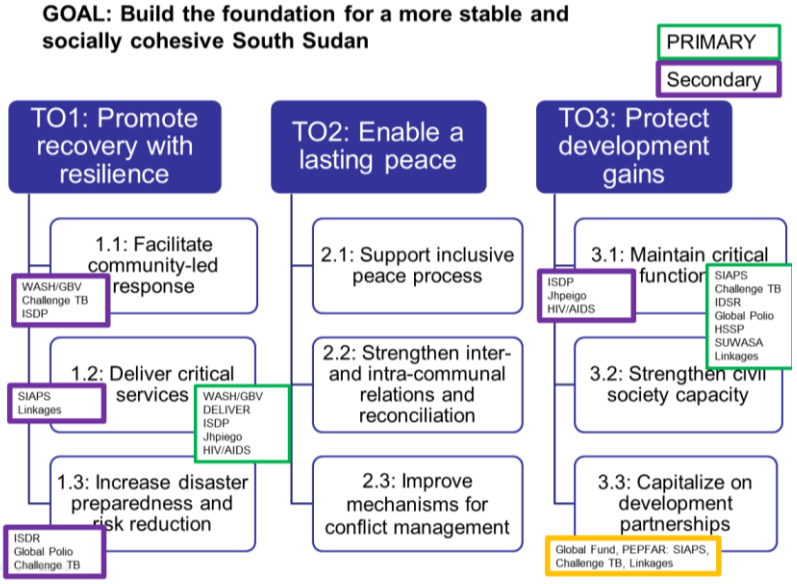


Figure 4: USAID health portfolio programs linked to transition objectives[43]

Overview of USAID Programs

USAID implements a number of programs to address the six heath systems pillars as listed below:

ISDP: Increase access to high-quality primary health care (PHC) services for all people in CES and WES in South Sudan.

HSSP: Increase ownership and capacity of SMOHs and CHDs to ensure the provision of high-quality primary health care services.

SIAPS: Assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes.

DELIVER: Provide essential medicines and health commodities to cover all of South Sudan for one year due to nationwide stockout.

IDSR: Reduce morbidity and mortality caused by epidemic prone diseases/communicable diseases, through strengthening of the integrated disease surveillance system in SS and building the capacity of PHC workers, state and county health authorities.

[43] Supplement to Operational Framework, pprovided by USAID health team

Each program focuses on different aspects — from service delivery to finance, leadership to governance. ISDP and HSSP have a specific geographic mandate, while SIAPS, DELIVER and IDSR are nationwide in scope. SIAPS and DELIVER focus on pharmaceutical procurement and strengthening the management and distribution within the drug supply chain. DELIVER is the implementing arm of the EMF, whose donors are USAID, DFID, and Norway. IDSR is implemented by WHO and provides essential disease surveillance functions at decentralized levels. There are no other donors that support these essential programs to the degree in which USAID does currently.

TABLE 5: COMPARING PROGRAM FOCUS BY PILLAR

Pillar	ISDP	HSSP	SIAPS	DELIVER	IDSR
Service Delivery	X				
Human Resources for Health	X	X			
Health infrastructure	X				
Pharmaceuticals, medical supplies & equipment			X	X	
Supervision, monitoring & evaluation	X	X	X		X
Finance, leadership and governance		X			

Unique features

USAID's health portfolio has several unique support areas when compared to the other donor-funded programs. The HLA identified seven unique features:

1. The prevention of postpartum hemorrhage through community-based services

Postpartum hemorrhage is one of the main causes of maternal deaths in South Sudan.[44] ISDP extended support for safe deliveries and the reduction of maternal deaths beyond the recommended MOH BPHNS, to include the distribution of misoprostol at the community level through the Home Health Promoters (HHPs). ISDP conducted a learning phase in 2013 and expanded to five counties in CES and WES in 2014.[45] Donor-funded programs in other states and the national MOH have benefited from ISDP's technical expertise, with the distribution expanding to seven states in 2015..

2. Quality improvement standards implemented at the health facility level

ISDP has led the introduction of a quality improvement tool, Standards-Based Management and Recognition (SBM-R). ISDP has rolled out specific standards associated with infection control to all 16 counties,[46] an area that the MOH Health Facility Survey identified as a critical gap in PHCUs and PHCCs.[47] Information has been shared with partners through the Quality Improvement Working Group.[48] The approach has been stated to be useful to health facilities and there are plans for expansion, to utilize further standards associated with antenatal care, delivery and post-partum care.[49]

3. Leadership and management training and mentoring

HSSP has led the development of a training and mentoring program for leadership and management.[50] The program is for three levels SMOH and CHD managers, health facility in-charges and VHCs.[51] Interviews with the national MOH, SMOH and CHDs consistently stated the usefulness of the program, and CIPs noted increased uptake of management responsibilities by the CHDs.

[44] "Advance distribution of misoprostol for the prevention of postpartum haemorrhage in South Sudan", Smith et al. 2014
[45] ISDP Annual Report October 2013-September 2014, USAID/Jphiego, 2014
[46] HSSP Year Two Annual Report, USAID HSSP, 2014
[47] Rapid Health Facility Survey, MOH, 2013
[48] ISDP Year Two Annual Report, USAID ISDP, 2014
[49] Ibid
[50] HSSP Year 2 Annual Report ,USAID HSSP, 2014
[51] Interviews Notes HSSP, WES

4. Pharmaceutical supply management support

SIAPS is able to provide pharmaceutical support management at the national, state and county levels, which is not provided by any other partner. At the national level, support includes drug quantification, communication across national to county levels about drug distribution, information sharing to partners, and coordination of the EMF Technical Working Group.[52] In 2014, SIAPS also led the nationwide de-junking process alongside all key donor-funded programs.[53] At the state level, SIAPS has placed technical support in CES and WES ministries.[54] SIAPS has provided training in areas such as stock-keeping to specific counties and facilities, and is piloting a pull system in four counties.[55]

5. Emergency Medicines Fund procurement and supply process

The DELIVER program has led the procurement process for the EMF and other critical health commodities. The program also provides safe and adequate storage while in transit and distribution to the CHDs. At the central medical stores (CMS) it has provided equipment, training, and standardized procedures for storage and inventory control. DELIVER is currently renting warehouse space at the national level for EMF supply, as the CMS is at full storage capacity.[56]

6. Integrated Disease Surveillance and Response (IDSR) program

IDSR is implemented by WHO and provides essential disease surveillance functions at all levels of the health system. Critical functions include, emergency preparedness and response planning, weekly disease surveillance reporting system, community based surveillance and training.[57]

7. HIV/ AIDS commodities and technical support

PEPFAR is currently the single largest HIV donor.[58] Given ongoing uncertainties around South Sudan's recent application to the next Global Fund round, PEPFAR has provided HIV treatment bridge funding, commodities and technical assistance through the Supply Chain Management System (SCMS) and Columbia University-ICAP[59]. The US Centers for Disease Control (CDC) provides additional lab systems strengthening and quality assurance capacity building, including support to the Antenatal Care (ANC) Surveillance Survey.[60] Additional programs include strengthening HIV treatment including PMTCT Option B+, and 'Linkages', which will focus on sex workers and high risk populations.[61]

Gap Analysis across the Six Pillars

The HLA covered all levels of the health system from national to community, highlighting gaps across the entire health system, which were not necessarily linked with one program or donor. The analysis draws on interviews, field observations and referenced documents. The analysis did not delve into the specifics of ISDP's service delivery and community activities as these will be described in detail by the ISDP Mid-Term Evaluation.

Service Delivery

Access: Field observations and interviews confirmed that the majority of primary health care level service delivery is led by ISDP/CIPs in both states, without which service delivery would not be possible. User fees are requested for primary services; however, the degree of formality differs from location to location. For example, the HLA team observed a formal pricing scheme clearly described in one facility.

[52] Interview Notes with SIAPS and USAID feedback
[53] SIAPS Quarterly Report, Project Year 3, Quarter 4, USAID/SIAPS 2014
[54] Field visits and SIAPS interview Notes, April 13 2015
[55] SIAPS Quarterly Report, Project Year 3, Quarter 4, USAID/SIAPS 2014
[56] Interview Notes with DELIVER
[57] Annual IDSR Report: Year 6, USAID, 2014
[58] US President's Emergency Plan for AIDS Relief: South Sudan 2014 Country Operational Plan
[59] Ibid
[60] Interview Notes with MOH HIV Directorate
[61] Notes from USAID on planned Linkages program

Services: Inconsistent implementation of family planning services was noted in both states, with some facilities lacking family planning commodities. The gap can be partly attributed to the exit of Marie Stopes International. United Nations Population Fund (UNFPA) recently conducted a survey of CIPs, which stated the majority of supplies requested were received; however there were some gaps in family planning commodities including implants.[62]

Secondary care: There is limited support for strengthening county or state hospitals in the two states, compared to other states of South Sudan[63] and there is a weak referral system from primary health care facilities to the hospital level.[64] There is a potential risk of a gap in essential secondary health care due to the imminent departure of MSF from Yambio State Hospital.[65] Partners have to work together to ensure the continuation of any system functions affected due to MSF leaving; e.g. the partners are sharing the costs of maintaining the state ambulance.[66]

Human Resources for Health

Health facilities have more staffing available compared to previous programs,[67] with all PHCCs visited having skilled birth attendants. However field interviews confirmed that the majority of skilled birth attendants are paid for through the CIPs, rather than by the government. In addition, health workers are reporting that there are not enough opportunities to obtain places at the institutions in order to upgrade their skills. There is no plan for transitioning staff paid by CIPs to the CHD payroll, which is a key assumption of the ISDP design.[68]

Interviews at all levels confirmed that the shortage in skilled health workers across the country has created competition between the CIPs and the other service delivery NGOs. The competition is compounded by: the different salaries and benefits offered, some CIPs paying salaries in USD, the large gap between the Harmonised Salary Scale and the government salary, and not all CIPs using the Harmonised Salary Scale. The disparity has caused demotivation of government health workers, with interviewees reporting that government workers may come to work for half the day. There were also reports that government health workers were joining the CIP payroll.

The MOH HRIS is a tool for firstly capturing and tracking who is doing what, where, and with what qualifications, which then can be used to analyze human resource utilization and develop plans for all levels of the health system.[69] There is no overall staff listing showing government and CIP health workers, and there are no immediate plans for piloting the HRIS in CES and WES.[70]

Infrastructure

Field observations showed ISDP funds are being used for minor renovations and equipment at facilities; HSSP has bought office equipment such as furniture and laptops for CHDs and SMOHs.

Major renovation and construction has been completed by CIPs and CHDs e.g. CIPs leveraged external funds to construct buildings[71] (see Figure 5a); CHDs are using their County Operating Grants for facility renovation and in one location to construct a drugs store[72]; other organizations such as UNOPS and FBOs have previously constructed facilities. However renovations do not seem to be planned in a systematic way based on a county-wide needs assessment.

Field visits showed that VHCs are leading construction of basic mud tukuls (traditional housing) to be used as PHCUs and staff housing. In one PHCU, the VHC constructed a new building to expand the space available for the PHCU (see Figure 5b). Even though a minority of CHDs and VHCs are

[62] Reproductive Health Commodity Supply in South Sudan: Case Study, UNFPA, 2015
[63] HPF have launched Requests for Proposals for County Hospitals and State Hospitals in 2014
[64] Interview Notes with Ezo, Yambio CHD, USAID and MOH
[65] Handover Roadmap for MSF Supported Service in Yambio State Hospital, MSF, July 2014
[66] Interview Notes with CIP and MSF
[67] Interview Notes with ISDP
[68] ISDP Task Order, USAID, 2012
[69] See http://www.hrisrss.org/about.php for a summary
[70] It is not clear if the HRIS has not been implemented as it is not authorized by USAID
[71] Interview Notes with CIPs
[72] Interview Notes with CHDs

constructing some health facilities, there is nonetheless a major gap in the support of infrastructure construction and renovation.

Figure 5: (A) Additional building constructed by the VHC, Ezo County - Mariagba PHCU (B) Maternity Unit built by a CIP using externally sourced funds, Ezo County - Naandi PHCC

Pharmaceuticals, Medical Supplies & Equipment

It was evident from interviews and field visits that the availability of essential medicines has improved in the last year because of support from DELIVER and SIAPs; however it is estimated that mass stockouts may begin by October 2015.[73] The "push system" continues to operate, whereby essential medicines are sent in standard kits containing three months' supply for PHCUs and PHCCs. The kits are labelled for each health facility. DELIVER is responsible for bringing the supplies from the national CMS to the county level. SIAPS leads information communication with CHDs and CIPs. The CIPs are responsible for the supply chain from the county stores to health facilities, including storage and consumption monitoring at the facilities.[74]

Good Practice Example

Before EMF, the RRHP centrally procured a limited number of essential drugs to fill gaps, creating small essential kits for facilities. Kit sizes were based on service utilization data.

The facilities visited did not have enough storage for a three month supply, leading the counties to store a large proportion of essential medicines in county stores. Although partners recognize the importance of establishing a pull system between the CHD and the facility, no location visited had managed to do this. The county stores are not being used as an organized drug depot but only for storage, and health facility stockouts are dealt with on case by case basis. Key features to make the pull system function were not available at the county stores visited, such as completed stock cards, space to unpack all kits, staff capacity and access to transport other than by CIP vehicles.

[73] Interview Notes Health Forum Advisory Team and DELIVER
[74] Summary of findings from field observations, Interview Notes with CHDs, CIPs, SIAPS and DELIVER

Figure 6: (A) Ezo CHD store does not have enough space to open and sort 2nd quarter supplies; 3rd quarter arrive tomorrow (B) EMF 3rd quarter supply arrives on time at Yambio CHD

The assessors found that there were stockouts in several facilities; in one facility, which was not on the EMF distribution list, amoxicillin, paracetamol and ferrous sulphate were out of stock. Where a facility is missing from the list, or miscategorized, the push system adds another challenge in transporting drugs from one facility to another.

Supervision, Monitoring and Evaluation

Throughout the field visits, interviewees expressed that CHDs have increased their leadership and management roles since the new USAID programs have begun.[75] However the CHDs lack capacity in more medical/technical areas, relying on CIPs for their expertise (e.g. overseeing service delivery protocols). The MOH Quantified Supervisory Checklist (QSC) is consistently used by CIPs, CHD and HSSP; however there seems to be parallel supervision systems where CHDs supervise facilities (with support from HSSP),[76] CHDs and CIPs jointly supervise facilities and CIPs independently supervise facilities.[77] CHD training on supervision is provided by HSSP.[78] CIPs are also implementing the SBM-R process; however neither the CHD nor HSSP are utilizing this approach.[79]

The HMIS health facility monthly report is being implemented across all the counties and facilities visited, with CHDs and CIPs identifying few issues and high reporting rates.[80] Data quality checks are conducted at the facility level, by all CIPs either quarterly or monthly.[81] HSSP has previously supported the national MOH scheme of annual data cleaning;[82] however there are no standard supervision tools for regular HMIS quality checks. The data collected is used by HSSP to develop published bulletins and for use in the monthly county coordination meetings; however there is little evidence of sharing data across USAID programs at the local level. For example, DELIVER may find it useful to compare the HMIS drug consumption against supply.

The IDSR and HMIS are treated as two separate systems at the local level. The IDSR health facility weekly surveillance reporting seems to have been implemented inconsistently. In WES, interviews with the CHDs and CIPs revealed almost all facilities provide the HMIS monthly reports on time; however, the weekly IDSR is much more inconsistent.[83] CIPs stated that their focus has been the HMIS monthly report rather that the IDSR.[84] However, in Juba county the CHD stated the weekly reporting is functioning well..

[75] Interview Notes with CIPs, national MOH, HSSP
[76] Interview Notes with CHDs
[77] Interview Notes with CIPs and ISDP; Annual Report October 2013-September 2014, USAID/Jphiego, 2014
[78] Interview Notes with HSSP
[79] Interview Notes with CIP and ISDP
[80] Interview Notes with CIPs and CHDs
[81] Interview Notes with CIPs
[82] Report on the Data Quality Workshops, MOH, 2014
[83] Interview Notes with CHDs
[84] Interview Notes with CIPs

Finance, Leadership and Governance

In November 2011, before the main programs (HPF, RRHP, ISDP and HSSP) began, the donors and MOH held the Donor Harmonization Meeting to align the programs to an essential list of services and HSS areas of supervision and reporting.[85] During implementation of the main donor programs, only one coordination meeting has been held between the MOH, donors and main programs.[86] Such formal strategic coordination is noted by the MOH and donors[87] as a gap in ensuring a more harmonized approach. In 2015, the main health donors, the MOH and MOFEP are drafting a Donor Health Compact outlining responsibilities and benchmarks for the sector.

CIPs interviewed regularly share work plans with the CHD, and help to develop specific plans for activities such as EPI campaigns. HSSP supports CHDs to develop supervision plans, prepare, and execute county transfer budgets and run county coordination meetings.[88] HSSP also leads the Leadership and Management training program.

> Good practice example:
>
> The HPF has implemented a "one-plan" model for the county that includes all partners, in the county. The plan is written to cover all six health system pillars.

HSSP's original Task Order stated: "HSSP will work with the respective counties to ensure the development of their health plans and then their consolidation at the state level. Similarly, HSSP will work with the SMOH to ensure the development of their plans". Comprehensive planning linking the CHD, SMOH and MOH is not available. At the local level, no CHD has a county plan that includes the activities of government and all partners or inter-sectoral projects (e.g. the Logoseed[89] or other CBO/FBO activities). There is also no work plan or strategic plan available for the SMOH.[90] There is therefore no evidence of any linkage between the CHD and SMOH plans and the national-level HSDP strategy.

At the community level, the majority of facilities are reported to have a functional VHC;[91] all facilities visited had functional VHCs. Their responsibilities surround mobilizing the community for campaigns, construction, clearing space and helping to raise awareness on key health messages.[92] HSSP has the responsibility to train the VHCs in leadership; however, by projecting possible participant numbers, HSSP will not be able to train all VHC members in the program period.[93] Finally the HLA found little use of any community based organizations for health promotion activities.

ISDP AND HSSP MODEL ANALYSIS

Strengths

Overall

Among the strengths of USAID's design approach, the split between the ISDP and HSSP has meant that both are able focus and direct resources to a more specialist mandate, simplifying management and priority-setting.[94] The design of each program ensures that there is greater presence, support and coordination at decentralized levels of government, particularly at the county levels, than has previously been provided. Both programs have a presence in the CES and WES state capitals and they engage in regular county and state coordination platforms; the monthly County Coordination meetings and the Quarterly Review meetings respectively. This enables regular, formal communication to better enable coordination between the programs and Government.

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[85] Summary of the November 2011 Donor harmonization Workshop, MOH, November 2011
[86] Donor Harmonization Workshop held on 5th June 2013
[87] Interview Notes with National MOH and donors
[88] Interview Notes with CHDs and HSSP
[89] Providing local government PFM support, including piloting Payam Development Grants in several counties including WES, CES.
[90] Strategic Plans for Western Equatoria and Central Equatoria State 2011-2015 are available for the state, with little information on health
[91] 305 out of 364 facilities reported in ISDP Annual Report October 2013-September 2014, USAID/Jphiego, 2014
[92] Interview Notes with CHD, CIPS and health facilities and the Focus Group Discussion
[93] Interview Notes with HSSP
[94] Interview Notes with CHDs, HSSP, ISDP, CIPs

Service Delivery

The ISDP program is based on a harmonized approach to basic service delivery with the other main fund managers and the Basic Package of Health and Nutrition Service, in an effort to ensure equity and quality control across the country. The introduction of CIPs, mean that CHDs have one main partner with whom to work and coordinate. This reduces the confusion that was seen under previous service delivery models reducing gaps and duplication of activities.[95]

The ISDP model focusses on the link between health facilities and their community, with support to VHCs and HHPs.

Systems Strengthening

The HSSP design allows focused systems strengthening support to CHDs. HSSP has supported higher execution rates of the Conditional Operating Transfer, implemented the Leadership and Management program, supported improved CHD HMIS monthly reporting and developed regular HMIS bulletins.[96]

The introduction of the hub model has provided CHDs a platform for meeting regularly to share information and lessons learned.[97] It has increased communication between HSSP and the CHDs, enabling improved planning and information sharing between HSSP and the CHDs. It has also increased the program's visibility at the county level.[98]

Weaknesses

Overall

The initial Donor Harmonization Meeting aligned all three core programs in 2011. The design of the programs assumed the progressive transition of health service delivery to national MOH, SMOH and CHDs "within the near future".[99] The commitments made by the national MOH in 2011 included developing a Memorandum of Understanding (MOU) between the government and each program, holding quarterly review meetings between the programs and the government, and engaging with the Ministry of Labor and Public Services on increasing health worker salaries.[100] The actions were to support the programs' transition of services over time to the government. However, neither the MOUs nor quarterly meetings were implemented, with little formal discussion on responsibilities between the government and the donor community, until the drafting of the recent Donor Health Compact.

The design of the two programs, in particular the design for their collaboration and coordination, does have some weaknesses. There is a duplication of overheads as each program has its own offices, support staff, vehicles and equipment.[101] The HLA team visited four counties and two state headquarters and found no examples of the programs co-locating with each other, or with government. As well as the cost implications, this has an impact on day-to-day coordination and flexibility in responding to each other's plans.

The targeted focus on county level support has unintentionally by-passed the state level administration. As well as less support at state level, there is no decision making platform between ISDP, HSSP and the SMOH and CHDs to strengthen the SMOH's stewardship role. Despite this, the HSSP organigram is heavily weighted towards staff located at the state, which is in contrast to its focus on county level capacity building.[102]

Service Delivery

[95] Interview Notes with CHDs
[96] Ibid
[97] Interview Notes with CHD
[98] Interview Notes with HSSP
[99] Draft Workshop Report Donor Harmonization Meeting, Joint Donor Team, 2011
[100] Ibid
[101] Field work observations
[102] HSSP Year Two Annual Report, USAID HSSP, 2014

ISDP program design is based on the gradual transition of responsibilities over phases. A key assumption of the ISDP design is that the MOH would be able to transition staff paid by CIPs to the MOH payroll; [103] there is no plan for such a transition to occur.

At the community and facility levels, there are multiple structures supported by HSSP and ISDP-CIPs, creating potential duplication of efforts:

- VHC and health facility leadership training is the responsibility of HSSP;[104]
- ISDP's CIPs are establishing Community Mobilization Teams (CMTs) independent of HSSP work with VHCs; [105]
- The roles between the VHCs and CMTs are not clear;
- It is also unclear how the CMTs or the VHCs link with the CHD;[106]
- Furthermore CIPs, HSSP and the CHD are conducting data quality assurance visits an area of potential overlap.[107]

ISDP's specific mandate lacks flexibility in critical areas:
- In-ability to take on secondary level care, in particular the gap created through MSF's withdrawal from Yambio State Hospital;[108]
- Critical drug procurement in the event of emergencies/stockouts;
- Infrastructure development where other partners cannot support shown by the continued need for county storage.

Systems Strengthening

There are several omissions to the design of ISDP and HSSP:

- IDSP's Task Order expresses the likelihood of stockouts, while HSSP's Task Order refers to the need to track pharmaceutical supply.[109] However, there are responsibilities assigned in either Task Order for managing the county to facility level pharmaceutical supply. In reality, field visits showed that the responsibility falls to the CIPs.
- No support to long-term pre-service training leading to dependency on other partners for the production of skilled health workers from the six pre-service training institutions in CES and WES;[110]
- Limited coordination between the USAID programs at the local level (e.g. HSSP, ISDP and SIAPS holding regular briefings);
- According to the task orders, ISDP have the responsibility for tracking CIP health workers and HSSP is responsible for workforce planning, however neither task has been implemented.

The hub model has a number of disadvantages: [111]

- From interviews with HSSP and the design documents provided, the model bypasses the SMOH-CHD link and has little engagement of the SMOH;
- Logistically costly, as staff will need to travel regularly between counties currently requiring hiring of vehicles;
- .It is inflexible to respond to immediate needs, if the Hub Officer is busy in another county;
- Does not involve the CIPs or other service providers;
- Trips are short (often one day) and therefore time with the CHD limited.

[103] ISDP Task Order, USAID, 2012
[104] HSSP Work Plan for Year 3, USAID HSSP, 2014 and Interview Notes
[105] Interview Notes with CIPs
[106] Interview Notes with CIPs and HSSP; Field observations
[107] Interview Notes with CIPs, HSSP and CHDs
[108] Interview Notes with MSF
[109] ISDP Task Order, USAID, 2012 and HSSP Task Order,
[110] Juba College of Nursing and Midwifery, Juba Health Science Training Institute, Juba Nursing and Midwifery School, Kajokeji Health Training Institute, National Health Training Institute-Maridi, Lui Midwifery School
[111] Interview Notes with HSSP, CHDs and CIPs

CONCLUSIONS

OPPORTUNITIES

There are numerous opportunities to enhance the performance of both ISDP and HSSP within the current design model. A key opportunity is to use USAID's Operational Framework to establish a clear health strategy, and in turn realign the ISDP and HSSP approaches based on, USAID's unique features within the health system, the gaps highlighted in this assessment and the activities of other donors.

As program end dates approach for ISDP, HPF and RRHP, USAID has an opportunity to harmonize approaches with other donors nationwide; both to fill gaps in its own program locations using other donor unique features, and to roll-out USAID's unique technical expertise more widely. The diagram below summarizes the activities supported by donors in South Sudan as described in the Research Findings, highlighting activities that are unique, common and critical in the health system:

- USAID has many unique features which are not implemented by other donors, such as the quality improvement tool SBM-R, or the DELIVER program procurement process.
- Other health programs also bring unique features to South Sudan discussed in the Research Findings, such as the support to training institutes (Canada and EU), oversight committees (HPF), secondary heath care (HPF and RRHP) and performance based contracts (RRHP).
- There are activities common to all core health programs, listed in the center (empowering VHCs, supporting primary health care, CHD support and conducting joint supervisions).
- The critical activities of medicines procurement and infrastructure are noted in the health system, but are not features of any particular program. Nationwide medicines procurement relies on EMF; however HPF and RRHP have the flexibility to procure additional supplies. Infrastructure is critical; however there are major gaps in support.

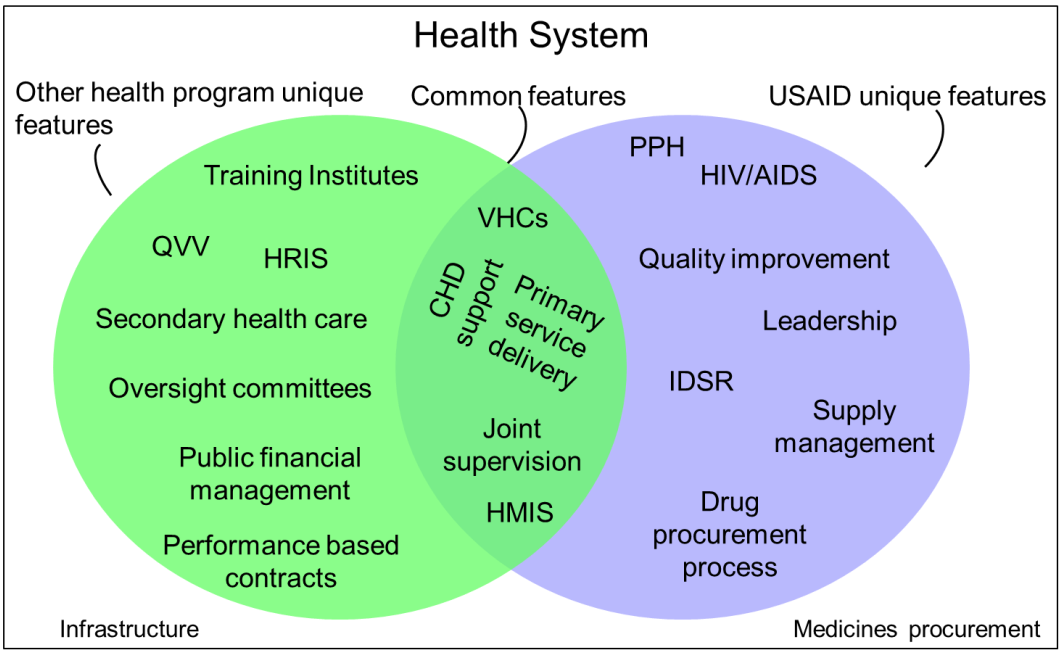

Figure 7: Unique features of USAID and other donor programs

Further opportunities include:

- Address weaknesses in the current ISDP/HSSP design through stronger collaboration between the two programs vertical programs and other stakeholders.

- Learn lessons from other fund managers, such as the HPF's approach to establishing state oversight committees and co-locating/embedding staff to accelerate capacity building, or RRHP's contracting approach
- Utilize the increased capacity of the VHCs and CHDs by handing over more responsibility to them. This will allow the programs to focus on other areas of priority, or to help address areas in which they are restricted. Some of these areas could include technical supervisions (CHDs), budgeting and budget execution (CHDs) and addressing infrastructure needs (CHDs and VHCs).
- Engage with FBOs and CBOs already operating in complimentary areas to the USAID funded programs.[112]
- Utilize the HRIS as a step towards addressing staffing shortages and enabling the decrease in salary gap between government and NGO health workers through the Infection Allowance.
- Make better use of drug consumption data and support SIAPS' role. This data would support strengthened pharmaceutical supply management (PSM) at the facility and county levels.

THREATS

Many of the threats to USAID's health programing have already been referenced in the PEST. The health sector is being affected both economically and socially by the lack of an imminent peace agreement, the continued internal conflict and tensions with Sudan. Massive displacement is necessitating the creation of IDPs camps and a humanitarian response, with an increased risk of outbreaks. In addition to this, lowered oil production has limited government revenue and therefore increased the reliance on domestic borrowing. This is leading to a widening fiscal gap and, of particular concern to the health sector, depreciation of the SSP and an increase in operating costs.

The initial design assumed that the Government will be able to take on more responsibility at national, state and county levels. Although the HLA has observed increased responsibility and leadership at the county level, national government has not been able to increase its responsibilities for critical areas such as the transition of staff paid by CIPs to the MOH. The widening fiscal gap further undermines any ability of the government to increase its responsibilities in health care. Therefore the expected transition of the programs may not be possible.

With the DELIVER program due to end in June 2015 and drug supplies likely to be exhausted by October 2015, nationwide stockouts are a key threat to health service delivery and could have the potential to impact long-term health seeking behavior. Unlike the HPF and RRHP, CIPs under the ISDP are not able to procure drugs and will therefore face the biggest challenges in the event of a gap. In the short term, there is a widespread expectation that USAID will continue to fund and lead drug procurement in absence of a successful government procurement, which threatens the availability of funding to other programing for its health portfolio. The lack of any long term strategy for pharmaceutical procurement means that South Sudan will continue to suffer from the threat of widespread stockouts on an annual basis.

There is an emerging threat of 'mission creep' as the needs change and Government increasingly turns to donors to cover more services and support functions, requiring a flexible approach. HPF and RRHP have taken on more responsibility since the Donor Harmonization Workshop in 2011, for example in secondary health care. As service delivery programs are due to end over the next 12 months, this leaves a short window to capitalize on development partnerships and design options may become limited unless there is immediate engagement with the donor community. Without capitalizing on development partnerships and unique features, it is likely that contributions from each individual donor, even if maintained, will lead to gaps. The Donor Mapping has started to list contributions; however it is incomplete and any future planning needs an accurate picture of resource allocation.

In addition:

[112] For example, the Comboni Sisters in Ezo County are supporting secondary and tertiary care

- The emergence of a humanitarian industry will bring increasing implementation costs that will impact on non-humanitarian programs, putting increased pressure on donors and government. All parties will therefore find it difficult to maintain current levels of program delivery, further threatening progress to date.
- USAID is reliant on other donors for pre-service training of skilled health workers. Competition continues for the current pool of skilled health workers and therefore staff turnover will continue, exacerbated by high demand, pressure from health workers to pay in USD, and the differing salary and benefit packages,
- Areas within the health system that are currently under-supported will deteriorate further. For example, the functionality of the IDSR was found to be inconsistent across the two states. With a weak health system and limited resources, containment of any outbreaks will be a hampered.
- The lack of support to maintain and develop health infrastructure will accumulate to a critical scenario which will be more expensive to address in the future; and is, in the meantime, detrimental to health services (including the storage of pharmaceuticals).

RECOMMENDATIONS

OVERVIEW

Recommendations have been split into immediate - those that should be implemented within the current ISDP, and HSSP program timeframe - and future - those that relate to the next program cycle. Three potential scenarios have been outlined in order to make realistic recommendations. The scenarios are:

- Deteriorating: Government decreases funding for salaries and pharmaceutical supplies. The humanitarian situation worsens and spreads to other states, increasing implementation costs.
- Unchanged: Government continues to prioritise state/county salaries. Infection Allowance expected for government health workers. Transition of NGO staff to government payroll is not expected. Government maintains small levels of support to secondary/tertiary health care. The humanitarian need continues but does not increase substantially.
- Improving: Government assumes more responsibility for salaries and pharmaceutical supplies. Government assumes more responsibility for secondary and tertiary health care. Facility grants implemented. The humanitarian need gradually decreases.

TABLE 6: RECOMMENDATION SCENARIO SUMMARY

	Deteriorating	Unchanged	Improving
Immediate	Modified Design	Modified Design	Modified Design
Future	OFDA + Collaborate	Collaborate	Current Model (or Collaborate)

In the immediate term, the current design will need to be modified no matter the situation, as the original design assumptions do not hold. If the situation deteriorates, USAID's focus should be on maintaining service delivery and continuing the support for emergency medicine funds. If the situation stays the same or improves, the modified design described in the next section is recommended. It is envisaged that the improving situation described above will not have a major impact on health activities until the next program cycle begins.

In the longer term, if the situation worsens, it would be expected that OFDA's mandate in health will grow geographically to all states, and there will be a need for USAID to capitalize on partnerships with other donors to maintain basic service delivery. In this case, as a minimum, implementing partners in CES and WES will likely assume responsibility for health workers and pharmaceutical supplies.

If the situation remains the same, USAID should collaborate with other donors to share unique strengths and initiatives; a pooled fund model should be considered. If the situation improves, the current design of ISDP and HSSP would be appropriate as the initial design assumptions will hold. However, even if the situation improves, due to the unpredictable environment of South Sudan, USAID should still consider collaborating with other donors to share unique strengths and initiatives.

IMMEDIATE RECOMMENDATIONS

Changes within the current funding envelope

1. Continue to support service delivery

It is clear that primary health care delivery in CES and WES is dependent on ISDP support for health worker salaries, technical supervision and logistical support. In particular, the dependency on ISDP (and the CIPs) to pay health worker salaries cannot be shifted to the government in the foreseeable future and therefore must continue.

2. Standardize salary payments to health workers

USAID and the fund manager Jhpiego must work with other donor programs to standardize the salary payments - including the use of USD or SSP for paying health workers - and guidance on benefits.

3. Increase oversight responsibilities of the CHD

Improving CHD oversight provides an opportunity to shift more tasks from USAID programs to the local government. In particular, full responsibility for the county coordination meetings and HMIS should be a short term goal.

4. Support the development of county and state plans

More focus should be placed on supporting the CHD and SMOH to develop realistic plans. The priority should be to develop a county plan and corresponding budget. This provides an additional opportunity to identify overlaps, gaps and improve collaboration across all actors in each county, including local organizations and faith-based organizations.

5. Simplify supervision at the health facilities

Integrate supervision at the health facility level, so that there is one main supervision per quarter between the CIP and CHD, led by the CHD. One tool should be developed integrating the QSC and the SBM-R processes; such a tool should balance the level of technical detail with the capacity of the CHD.

6. Increase emphasis on improving the IDSR reporting system

Additional emphasis should be placed on improving the IDSR reporting system across USAID programs and in collaboration with the CHD. Reporting rates for the HMIS monthly and IDSR weekly reports should be compared and counties needing additional support identified. Any plan for improvement should be led by WHO and involve HSSP and CIPs, as key USAID programs active at the county level. If mobile technology is an area of interest for USAID, using mobile reporting may improve surveillance.

7. Embed staff/Co-locate in the CHD and SMOH

CHDs and the SMOH would benefit from one-to-one support to increase their functionality. Embedding staff or co-locating in the CHDs and SMOH - rather than having parallel structures - will accelerate their responsibilities and decrease costs. Innovative methods should be looked at including partnerships between HSSP and CIPs, to provide the embedded support and share operational costs.

8. Increase CHD and VHC responsibilities for infrastructure development

USAID should foster the ownership shown by the CHDs and VHCs towards infrastructure development. CHDs and VHCs could be supported, where needed, with costings, supervision and technical guidance. VHCs could be provided with small amounts of co-funding from either CHDs or USAID to develop better, longer lasting facility structures.

9. Shift responsibilities for supporting the VHC to the CIPs

All responsibilities of the VHC (including training), should be transferred from HSSP to the ISDP contracted CIPs. HSSP should provide technical support to the CHD and CIPs to roll out the available leadership program to the VHCs.

10. Initiate the Project Appraisal Document process

USAID should initiate the Project Appraisal Document (PAD) process. The process will help clarify the links between the USAID South Sudan Health Projects and the Operational Framework, and therefore articulate how the Projects and Activities will lead to the overall strategic results.

Changes that potentially require additional funds

11. Continue with the Emergency Medicines Fund for another year

With the drug procurement of the MOH stalled, stockouts predicted for October 2015 and no future plan for drug procurement, it is essential that support to the EMF continues. The cost of procuring one year's supply of essential medicines should be shared, as with the current EMF. The split of costs between the donors will need revisiting. The procurement must be complimented with an assessment of drug consumption and stock levels to quantify the expected severity of stockouts.

12. Focus pharmaceutical supply management support at the county level to improve storage conditions of the EMF supply.

A concerted effort is needed to improve the storage of the EMF supply. This needs to start immediately, and must involve all actors at the local level to pool resources available. USAID programs (e.g. SIAPS) should lead support on coordinating the response.

13. Provide support to roll-out USAID's service delivery technical expertise nationwide

Quality improvement and prevention of postpartum hemorrhage are two unique features of USAID's service delivery. These are critical service delivery activities needed across the country to support the overall goal of reducing maternal mortality.

14. Implement the HRIS as soon as possible

The HRIS is a critical step for implementing the government health-worker Infection Allowance, and to improve management more generally. USAID should support the startup and roll out of the HRIS as soon as possible in CES and WES. The HRIS implementation is the first step towards government health workers receiving their Infection Allowance, receipt of which will decrease the gap between CIP and government salaries.

FUTURE RECOMMENDATIONS

Changes to the current approach

15. Create a nationwide pooled fund for common service delivery and systems strengthening

Assuming that the funding envelope does not increase, a collaborative design approach is needed to capitalize on the unique program features of USAID and other donors, as summarized in Figure 7. This will allow greater harmonization of activities across the country and allow USAID to capitalize on other donors' strengths without starting new activities (for example pre-service training).

Pooling funds with other donors will reduce overall transaction costs and increase efficiency. It will allow USAID to shift responsibility for secondary and tertiary care to other donors, and decrease the reputational risk of focusing on two states and limited interaction with central government.

The HLA recognises that such an approach will be new for USAID South Sudan; however there is an increase in flexibility in USAID's administrative system that will facilitate the monitoring of pooled funds.[113] USAID has previously been part of the Afghanistan Reconstruction Trust Fund,[114] a 30-donor pooled fund managed by one fund manager, so there is some precedent for the engagement with Pooled Funds such as the HPF.

The timelines of core health programs provide an ideal opportunity to start discussing the new model design in June 2015, with the aim of aligning programs by June 2016. This gives USAID 12 months to complete the design and contracting process. The timeline is dependent on RRHP and HPF providing bridging contracts as shown by Figure 8.

[113] Interview Notes with USAID
[114] See http://www.usaid.gov/node/51786

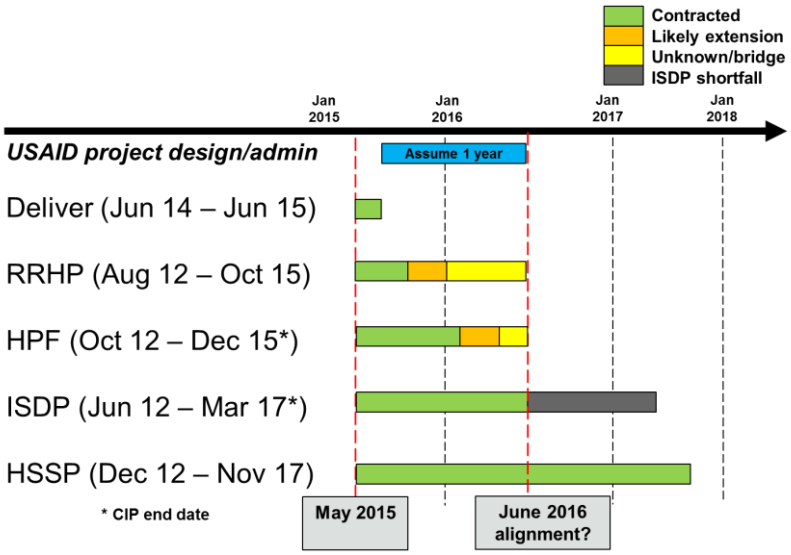

Figure 8: Potential alignment of key programs, with proposed bridging contracts

16. Assign technical lead agencies for USAID's unique features

Expand USAID's unique features by assigning nationwide technical leads and promote the approach with other donors to do the same for their respective areas of expertise. The table below summarises the potential leads based on the previously described unique features.

Table 7: Summary of potential lead partners

Unique Feature	USAID Partner
The prevention of postpartum hemorrhage through community-based services	Jhpeigo
Quality improvement standards implemented at the health facility level	Jhpiego
Leadership and management training and mentoring	Abt Associates
Pharmaceutical supply management support	Management Sciences For Health
Emergency Medicines Fund procurement process	John Snow Incorporated
Integrated Disease Surveillance and Response program	World Health Organization
HIV/ AIDS commodities and technical support	Jhpiego and Family Health International[115]

17. Develop a longer-term framework for medicines procurement

It is unlikely that the Government will be able to take on substantial responsibility for medicines procurement. To avoid threats of nationwide stockouts reoccurring annually, USAID should work with other donors to develop a longer-term framework for medicines procurement.

18. Work with donors to develop a county storage infrastructure program

Whether pharmaceutical supplies are paid for by the donors or government, the issue of adequate storage needs to be addressed across the country. As a major contributor to the EMF, USAID should lead discussions with other donors on how this longstanding issue is going to be resolved.

[115] HIV/AIDs programming was briefly looked at in this assessment. The recommendation is about having specific leads, which already exist with HIV/AIDs projects, Jhpiego leading on PMTCT/Option B+ and FHI continuing with the Linkages program

Considerations

USAID

The restricted funding envelope will require tradeoffs to be made between supporting USAID's unique features, pooled funding and drug procurement - as shown by Figure 9. Furthermore USAID's health funding restrictions must be adhered to (e.g. earmarked funds for vertical programs). Assuming that 12 months is needed for the design process and completion of contracting, there is enough time to start developing a pooled fund if initial discussions and design work start by June 2015 (see Figure 8).

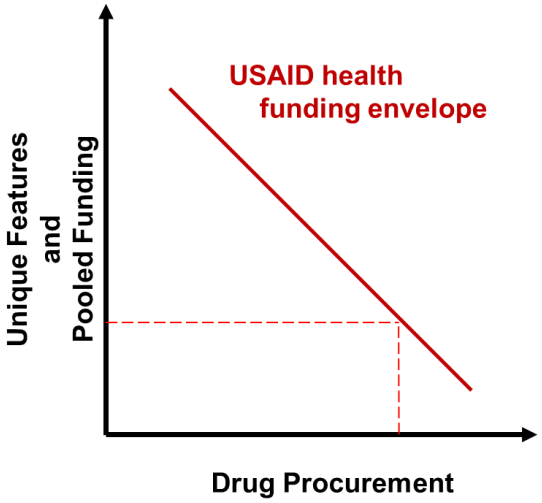

Figure 9: Illustration of USAID's trade-offs

Other Donors

USAID's commitment to changing its approach will be informed by other donor contributions and appetite for change and a national pooled fund. USAID will need to coordinate using bridging contracts to harmonize CIP end dates as shown in Figure 8. Donors will also have to commit to assigning technical leads for nationwide system strengthening and service delivery areas. USAID will be reliant on other donors for pre-service training of health workers. Any new pooled fund mechanism design, will need to be negotiated to suit all donors involved, and lessons learned from previous pooled funds must be taken into account. There have been specific concerns raised about the HPF management in terms of their technical leadership in maternal health and the quality of their financial systems.[116]

Government

Under the Unchanged Scenario, Government contributions are not expected to increase in the next few years. The Government needs to maintain their current commitments to salaries and county grants as a minimum; however any future program design needs to have built-in flexibility for the situation improving or deteriorating. If the Government states they will increase their commitments, an assessment needs to be made of how realistic this is, before incorporating it into the future program design.

In this regard, the Donor Health Compact currently being drafted is a useful opportunity for donors and government to be clearer about commitments and timelines to achieve agreed milestones; the development of the document itself serves as a platform for discussion and a means to inform program design.

Next steps

There are steps that can be taken to start discussions and analysis on the feasibility of the pooled fund. USAID should:

1. Discuss possibilities with the main funders about a nationwide pooled fund.
2. Develop costing models and design details for USAID's portfolio, based on the tradeoffs and as part of the PAD process.
3. Hold a joint review with other donors of the core health programs to collate lessons learned and best practices, and complete the Donor Mapping.
4. Co-lead, with the main donors, a consultation meeting about the future design with the wider donor community and the MOH.

[116] Health Pooled Fund: South Sudan Mid-Term Review Report, January 2015